

Research Highlights

Extending Health Care Insurance to Specific Populations

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Since the failure of national health care reform, efforts to increase health insurance coverage for the American people have focused on extending insurance to certain vulnerable populations, including children, employees in small businesses, substance abusers, the uninsured, and the near-elderly. In a series of studies, we have assessed the cost and consequences of various approaches to providing coverage for these groups.

to employees. Indeed, 60 percent of uninsured non-elderly workers are employed in small firms.

Medical savings accounts (MSAs), paired with a high-deductible catastrophic-insurance plan, have been proposed as a way to increase coverage for these workers. Employers would make regular, tax-deductible contributions to the MSA; an employee could draw on the MSA to cover health care expenses.

Children

The 1997 Children's Health Insurance Program (CHIP) is a federal-state partnership intended to extend health care coverage to a significant proportion of the nation's uninsured children. The program could substantially improve access for low-income, uninsured children.

Our analysis of the program's potential found that the program would increase physician contacts for these children from 2.3 to 4.6 visits per year, on average. However, as Table 1 shows, program effects will vary from state to state. The biggest potential improvements in access to care are in states that have traditionally provided the scantiest health safety nets.

Small-Business Employees

Much of the effort to get health insurance to the uninsured has focused on restructuring the small-business insurance market. Most of the non-elderly in the United States obtain their health insurance through their employers. However, small firms are less likely than large ones to offer health insurance benefits

Table 1: A CHIP-Like Program Would Substantially Increase the Number of Physician Visits for Uninsured Children, but the Increases Would Vary from State to State

The 10 States in the Robert Wood Johnson Foundation Family Health Insurance Survey	Physician Visits		Percent Increase
	Uninsured	Covered by CHIP-Like Program	
Colorado	2.5	5.1	104
Florida	2.3	3.8	65
Minnesota	3.4	4.8	41
New Mexico	1.7	4.0	135
New York	2.8	4.2	50
North Dakota	2.1	4.5	114
Oklahoma	2.3	4.5	96
Oregon	1.8	5.2	189
Vermont	2.0	4.7	135
Washington	2.5	5.4	116
Average	2.3	4.6	105

However, a simulation of the effects of MSAs suggests that MSAs will do little to expand the number of small businesses that offer insurance to their employees. The results displayed in Table 2 demonstrate that MSAs would only slightly increase both the number of small-business employees offered insurance and the number of small businesses offering it. Nonetheless, MSAs would be an attractive option for small-business workers who already have fee-for-service insurance.

Substance Abusers

Largely because of cost concerns, treatment for substance abuse has been excluded from recent federal and state legislation mandating parity (equal coverage for mental health and other medical conditions). We examined the use and costs of substance abuse treatment in 25 managed care plans that currently offer their enrollees unlimited substance abuse benefits with minimal copayments.

Providing unlimited substance abuse benefits in these plans costs employers slightly more than \$5.00 per plan member per year. A \$10,000 annual cap on benefits reduces the cost by only 6 cents. A \$5,000 annual cap reduces the cost to \$4.30 per member per year.

Limiting benefits for substance abuse saves very little but, as Figure 1 suggests, affects a substantial number of patients who need additional care. Patients who lose insurance coverage are likely to end treatment prematurely or to switch to public-sector coverage.

The Uninsured

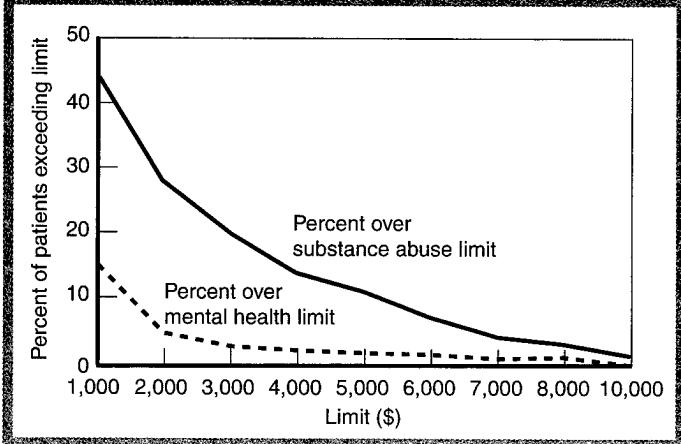
In the past five years, many states have proposed or implemented programs to provide insurance to low-income, uninsured residents. Estimates of program costs vary, but all aggregate estimates mask substantial variation. We have assessed extensive insurance, utilization, health status, and demographic information from 10 states that are, collectively, similar to all states in their health care systems and population characteristics, and that span the variation observed in all 50 states in important population and health-policy characteristics.

In these states, the proportion of the non-elderly population without insurance coverage ranges from 10 to 27 percent. Persons living in states with a higher percentage of uninsured are about twice as likely to be reported in fair or poor health

Table 2. Medical Savings Accounts Do Not Substantially Increase Either the Percentage of Employees in Small Businesses Who Are Offered Insurance or the Percentage of Small Businesses Who Offer Insurance

Scenario	Percent of Employees in Small Businesses Who Are Offered Insurance	Percent of Small Businesses That Offer Insurance
Without MSAs	41	36
With MSAs	43	38

Figure 1. Many Patients Who Need Additional Care Will Exceed Caps on Benefits for Substance-Abuse Treatment and Are Likely to End Treatment Early



as those living in states with a lower percentage. And residents in states with a higher percentage of uninsured have less access to care.

This variation in the uninsured rates means that some states will have to spend more per capita than other states to attain equivalent outcomes. Unfortunately, the states with the greatest need to extend coverage have the least capacity to do so. Nationwide, only half the states will be able to cover all of their uninsured with a budget limited to their tax capacity to finance health reform (see Figure 2). A state-by-state approach seems unlikely to solve the problem of the nation's uninsured. Many states will probably need targeted federal assistance—for example, a federal-state partnership like CHIP.

Figure 2. Only Half of the States Can Cover All of Their Uninsured with a Budget Limited to Their Tax Capacity to Finance Health Reform

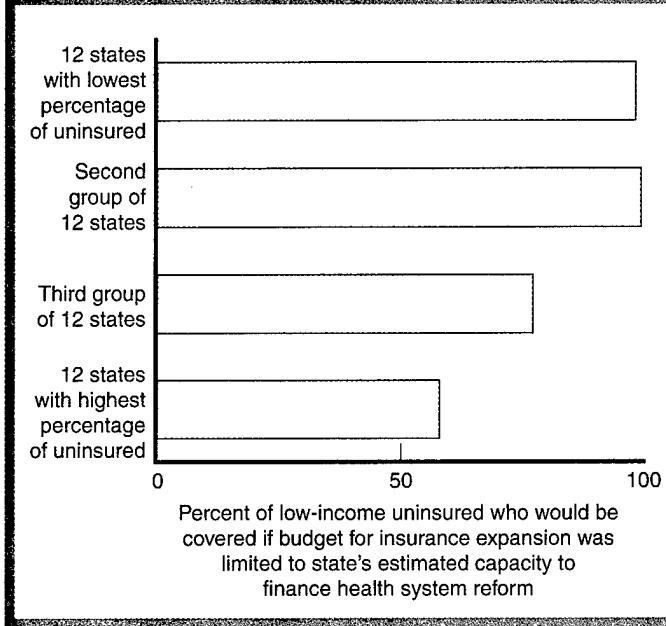
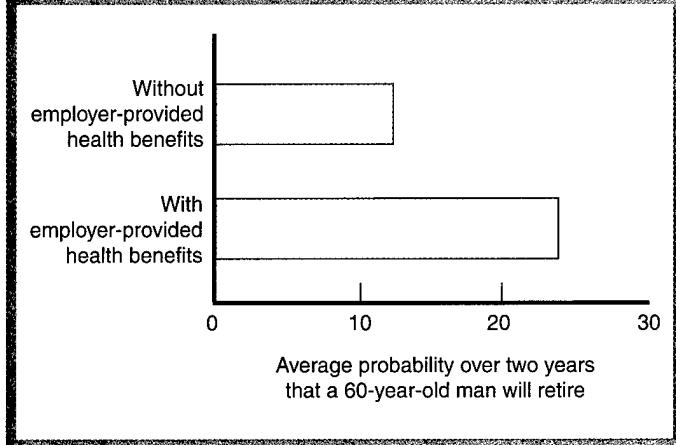


Figure 3. Retiree Health Benefits Such As Pension Benefits Are a Financial Incentive That Can Influence the Retirement Decision



The Near-Elderly

For insured workers contemplating early retirement, maintaining health insurance coverage is a significant factor. One in fourteen early retirees is uninsured. In a series of studies, we found that availability and cost of insurance after retirement have a strong influence on early-retirement decisions and on the percentage of the near-elderly who are uninsured.

Choices in health insurance coverage after retirement are limited. Before workers become eligible for Medicare at age 65, they can purchase an individual health insurance policy, rely on coverage through their spouse's employer-provided plan, or take advantage of extended insurance coverage that their own employers offer as a fringe benefit for early retirees. However, individual health insurance may be prohibitively costly and the value of fringe benefits for early retirees can vary widely.

Recent federal legislation provides other options. Under COBRA (Consolidated Omnibus Budget Reconciliation Act, 1985), insured workers in firms with 20 or more employees can continue their health benefits at 102 percent of the group rate for 18 months after retirement. The 1996 Health Insurance Portability and Accountability Act (HIPAA) allows workers with COBRA benefits to purchase private individual policies

with no preexisting-condition exclusions after the 18 months that COBRA covers. Insured workers in firms with fewer than 20 workers also have guaranteed purchase privileges in the individual market.

Our analyses showed that COBRA and HIPAA increase the probability that workers who retire before they are eligible for Medicare will be covered by health insurance. Nevertheless, more than one-fourth of uninsured retirees in the post-COBRA period had previously been covered through their own employers. These retirees were eligible through COBRA to continue their employment-based health insurance; however, they could not afford the health insurance premiums.

Our work also demonstrates that the availability of health insurance strongly influences male workers' decision to retire early. As shown in Figure 3, access to retiree health benefits increases the likelihood of retirement for 60-year-old men by about 50 percent, on average. However, the cost of insurance premiums dampens this effect.

Making insurance more accessible and less costly after retirement and before Medicare eligibility will increase workers' incentives to retire early and reduce the prevalence of the

near-elderly who are uninsured. Policies that reduce health insurance coverage options of early retirees will have the opposite effect.

Conclusion

Analyses such as those described in this review illustrate the complexities of designing effective programs for extending

health insurance coverage. Variations across the states in their ability to finance such programs and in the size of programs that would be required in each state are particularly influential factors. The simulated effects of MSAs remind us that policies, however carefully designed, may not accomplish what we intended. However, despite these challenges, we can anticipate that, at least in the near term, efforts to provide coverage to the nation's uninsured will continue to be focused on specific groups, rather than on the uninsured population as a whole.

For more information

Cantor, Joel C., Stephen H. Long, and M. Susan Marquis. 1998. "Challenges of State Health Reform: Variations in Ten States." *Health Affairs* 17(1):191-200.

Goldman, Dana, Joan Buchanan, and Emmett Keeler. April 2000. "Simulating the Impact of Medical Savings Accounts on Small Business." *Health Services Research* 35.

Karoly, Lynn A., and Jeannette A. Rogowski. 1994. "The Effect of Access to Post-Retirement Health Insurance on the Decision to Retire Early." *Industrial and Labor Relations Review* 48(1):103-123. (Also available as RAND RP-360, 1995, and in U.S. Department of Labor, Pension and Welfare Benefits Administration, *Health Benefits and the Workforce, Volume 2*, Washington, D.C.: U.S. Government Printing Office, 1998, pp. 197-217.)

Karoly, Lynn A., and Jeannette A. Rogowski. 1998. "Retiree Health Benefits and Retirement Behavior: Implications for Health Policy." In U.S. Department of Labor, Pension and Welfare Benefits Administration, *Health Benefits and the Workforce, Volume 2*, Washington, D.C.: U.S. Government Printing Office, Chapter Three, pp. 43-71.

Long, Stephen H., and M. Susan Marquis. 1999. "Geographic Variation in Physician Visits for Uninsured Children: The Role of the Safety Net." *JAMA* 281(21):2035-2040.

Marquis, M. Susan, and Stephen H. Long. 1997. "Federalism and Health System Reform: Prospects for State Action." *JAMA* 278(6):514-517.

Rogowski, Jeannette A., and Lynn A. Karoly. 1998. "COBRA Continuation Coverage: Effect on the Health Insurance Status of Early Retirees." In U.S. Department of Labor, Pension and Welfare Benefits Administration, *Health Benefits and the Workforce, Volume 2*, Washington D.C.: U.S. Government Printing Office, Chapter Four, pp. 73-93.

Sturm, Roland. 1997. "How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?" *JAMA* 278(18): 1533-1537.

Sturm, Roland, Weiyi Zhang, and Michael Schoenbaum. 1999. "How Expensive Are Unlimited Substance Abuse Benefits Under Managed Care?" *Journal of Behavioral Health Services & Research* 26(2):203-210.

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